MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10197

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days.

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3217 Connecticut Ave., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lella Bagg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	w	widowed

6.(b) Name of husband or wife Elisha Bagg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 21, 1878

8. AGE: Years	Months	Days	If less than one day
67	—	—	..... hrs. ..... min.

9. Birthplace Boston, Mass. (Town, county, and state)

10. Usual occupation Volunteer with Red Cross.

11. Industry or business

FATHER

12. Name Alva Clark

13. Birthplace Maine

MOTHER

14. Maiden name Alice Akers

15. Birthplace Maine

16. Informant Hospital Records.

Address Suburban Hosp. Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 10/23/45 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cem.

Location Maryland

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 10/23 19 45 Wm E Johns (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 19 45, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Angina pectoris	5 min.
Due to Coronary arteriosclerosis	? years
Due to Fibrosis of myocardium	? years
Due to	
Other conditions Cholelithiasis	? years

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results Below

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John Logan M.D. M. D. or other

Address 5001 Nevada Ave N.W. Date signed Oct 21 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

16198

FILM No. G 98 OCT 19 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Monty
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, Institution, or street address where death occurred: 232 Prospect St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 232 Prospect St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Baird

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife Alexander Baird
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14, 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hrs. ..... min.
59

9. Birthplace Scotland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Thurkey
13. Birthplace Scotland

MOTHER
14. Maiden name Mary Mac Bride
15. Birthplace Scotland

16. Informant Edward L. Graham
Address 232 Prospect St.

17. Disposition (Burial, cremation, or removal. Which?) Interment Date thereof 10/19/45 (month) (day) (year)
Cemetery or crematory Lewisberry, Pa.
Location Pa.

18. Funeral director Wm Rankin Trump & Grey
Address 7557 Wisconsin Ave. Bethesda, Md.

19. 10/9 1945 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1945 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1945 to October 8 1945
and that I last saw h... alive on October 8 1945

	DURATION
Immediate cause of death: Congestive Heart Failure	8 days
Due to: Portal Cirrhosis of Liver	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Portal Cirrhosis; Gall Stones Date of op. 8/20/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Sidney L. Gaverman M.D. M. D. or other
Address 3921 Lingan St. N.W. Date signed 10/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

10193

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Oct. 8, 1945

Hospital, Institution, or street address where death occurred:
Suburban Hospital - 8600 Old Georgetown Rd.

How long in hospital or institution? Since Oct. 8, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4403 Leland St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Mrs Mae Nicholson Baughmer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widow

6.(b) Name of husband or wife: Daniel Baughmer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1855

8. AGE:

Years	Months	Days	If less than one day
90	1	27	..... hrs. ..... min.

9. Birthplace: Riverside, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Chas. Nicholson
13. Birthplace: ? Pa.

MOTHER
14. Maiden name: Anne Morris
15. Birthplace: River — Pa.

16. Informant: Daughter - Mrs Lillian Curry
Address: 4403 Leland St., Chevy Chase Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 20, 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: S. A. Weis, & Co.

Address: 2901-14th St. N.W.

19. 10/18/1945 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18, 1945, at 11.50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to October 18, 1945 and that I last saw her alive on Oct. 18, 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	One week
With Pulmonary Infarcts	
Due to Senile Generalized arteriosclerosis	
Due to Fracture of left femur	
Other conditions	

(Includes pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ACCIDENT Date of: 10-7-45

Where did injury occur? Bethesda (City or town) Montgomery (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell on Floor Injured at work?

23. SIGNATURE: P. P. Andrews M.D. M. D. or other

Address: 4201 Fessenden St Washington D.C. Date signed: 10-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

16200

CERTIFICATE OF DEATH

Reg. Diat. No. 2 /

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs.

Hospital, Institution, or street address where death occurred: 4609 W. Va. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4609 W. Va. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Henry Beavers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife: Hannah F.

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1869

8. AGE:

Years	Months	Days	If less than one day
76	0	29	...hrs. ...min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Motorman

11. Industry or business

FATHER 12. Name: John T. Beavers

13. Birthplace: Va.

MOTHER 14. Maiden name: Mary Ann Kidwell

15. Birthplace: Va.

16. Informant: Mrs. Hannah Beavers

Address: 4609 W. Va. Ave. Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/10/45 (month) (day) (year)

Cemetery or crematory: Congressional Cem.

Location: D. C.

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 10/9 19 45 (Date rec'd by registrar) Mrs E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7/45 19... at 7:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1944 to Oct. 7th 1945 and that I last saw h... alive on Oct 5th 1945

Immediate cause of death	DURATION
Carcinoma of the rectum. (cancer)	1 yrs 8
Due to	
Due to	
Other conditions: Arteriosclerosis	5 years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Wheeler D. Hyatt M. D. or other

Address: Bethesda, Md. Date signed 10-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

10201

CERTIFICATE OF DEATH

★ Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
425 Hamilton Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Montour
City or town: Danville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 220 Mowry St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: GEORGE W. BLUE

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Clara S.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 26th. 1867

8. AGE: Years	Months	Days	If less than one day
77	10	27	..... hrs. ..... min.

9. Birthplace: Washingtonville, Pa. (Town, county, and state)
10. Usual occupation: Male Nurse retired
11. Industry or business

FATHER
12. Name: Martin Blue
13. Birthplace: Pa.

MOTHER
14. Maiden name: Sarah Billmyer
15. Birthplace: Pa.

16. Informant: Mrs. Clara S. Blue, wife
Address: 425 Hamilton St. Silver Spg. Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)
Cemetery: Oddfellows
Location: Danville, Montour Co. Pa.

18. Funeral director: Warne E Pumphrey
Address: 8434 Ga. Ave. Silver Spring, Md.

19. Oct 23 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23rd Oct. 1945, at 12:50 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 14th Oct. 1945, to 23rd. Oct. 1945 and that I last saw h. i. m. alive on 23rd Oct. 1945

	DURATION
Immediate cause of death: CONGESTIVE HEART FAILURE	UNDETER.
Due to: ARTERIOSCLEROSIS, GENERAL	UNDETER.
With Due to: HYPERTENSION,	UNDETER.
Other conditions: CYSTITIS, URETERITIS (LEFT) AND PYELITIS (BILATERAL) (Include pregnancy within 3 months of death)	UNDETER.

Major findings of operations: NONE
Date of op. .....
Autopsy results: NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. Marshall Linvillier Jr. M.D.
M. D. or other
Address: 720 Dale Drive Silver Spring, Md. Date signed: 23 Oct. 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-d)

10202

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH.
County Montgomery
City or town Kensington Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. #4 Chamberlain Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albert W. Bright

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife Mollie H
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 9. 1859

8. AGE: Years 86 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Patent Atty.

11. Industry or business

FATHER 12. Name John W. Bright
13. Birthplace Washington D.C.

MOTHER 14. Maiden name Myra Allen
15. Birthplace Mass.

16. Informant Dudley S. Bright
Address Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16, 1945 (month) (day) (year)
Cemetery or crematory Congressional Cem.
Location Washington DC

18. Funeral director S. H. Hines Co.
Address 2901 - 14th St NW DC

19. 10/14 1945 Wm E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945, at 1230 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Oct 14 1945 and that I last saw ____ alive on Oct 12 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	
Due to Carcinoma of Liver	
Due to Chronic Gastritis	
Other conditions Generalized Glandular Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury (Injured at work?)

23. SIGNATURE [illegible] M.D.
Address 1542 Columbia Rd NW DC Date signed 10/14/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10203

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Middlebrook Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural Middlebrook MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Ollie Bell Broadhurst

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Broadhurst
7. Birth date of deceased (mo., day, yr.): March 28 1868
6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
77	6	19	hrs. min.

9. Birthplace: Brownsingsville MD. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Home
FATHER 12. Name: Kaleb Beall
13. Birthplace: Brownsingsville MD.
MOTHER 14. Maiden name: Margaret L. Watkins
15. Birthplace: Brownsingsville MD.
16. Informant: Lansing E. Broadhurst
Address: Gaithersburg MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20 1945 (month) (day) (year)
Cemetery or crematory: Bethesda MD.
Location: Montgomery County MD.
18. Funeral director: Roy W. Barber
Address: Laytonsville MD.
19. Oct. 19 1945 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17 1945, at 12.40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 15, 1943, to October 17 1945 and that I last saw h.. alive on October 17, 1945

Immediate cause of death	DURATION
Cerebral thrombosis left	1 day.
Due to Arteriosclerotic cardio-vascular disease.	10 years.
Due to Senility.	5 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other
Address: Damascus, Md. Date signed 10/19/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

10264

Reg. Dist. No. 213-

1. PLACE OF DEATH:

County Montg.

City or town Rural near Potomac

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 54 years -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Bethesda, Md. R.F.D. #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert D. Brooks

3.(b) Social Security Number 579-03-7422

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Josephine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	6	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name Albert H. Brooks

13. Birthplace Va

MOTHER 14. Maiden name Emily Dunaway

15. Birthplace Va.

16. Informant Josephine Brooks

Address Bethesda, Md. R.F.D. #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/45 (month) (day) (year)

Cemetery or crematory Concord Church Cemetery

Location River Rd. Bethesda, Md

18. Funeral director Wm Reuben Dunphrey

Address Rockville, Maryland

19. 10/9/45 (Date rec'd by registrar) 19 Josephine E. Trotter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1945 at 9 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 10 1943 to Oct. 7 1945

and that I last saw him alive on Oct. 6 1945

	DURATION
Immediate cause of death: Arteriosclerosis / Chronic myocarditis	2 years.
~~Due to~~	
Due to Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm A. Linthicum M.D.

M. D. or other

Address Rockville, Md. Date signed 10/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

10205

Reg. Diat. No. 304

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Montgomery Co. Gen. Hospital Inc

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: LAY HILL

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RT # 1

(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR I

3.(a) FULL NAME: Francis James Buchanan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11/4/1894.

8. AGE: Years	Months	Days	If less than one day
51		23	..... hrs. ..... min.

9. Birthplace: Arizona (town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER — 12. Name: James Buchanan

13. Birthplace: Md

MOTHER — 14. Maiden name: Helen Warren

15. Birthplace: Vermont

16. Informant: Richard M. Beuchris

Address: Silver Spring Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1945 (month) (day) (year)

Cemetery or crematory: ARLINGTON NAT'L

Location: ARLINGTON VA.

18. Funeral director: Joe Gawler's Sons

Address: 1766 Pa Ave N.W. Wash D.C.

19. Oct 27 1945 (Date rec'd by registrar) Josephine M. Edes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/27/ 1945, at 7.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/ 1945, to 10/27/ 1945

and that I last saw him alive on 10/27/45 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	4 days
Due to: Cirrhosis of Liver	2 years
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed 10/27/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-B)

CERTIFICATE OF DEATH

*10206 216
Reg. Diat. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 11 days

Hospital, institution, or street address where death occurred:
enroute to N.H., Bethesda, Md.

How long in hospital or institution? 1 mo. 11 days
(on leave from hospital)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Missouri County:

City or town: Springfield,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 763 East Harrison
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BRYANT, Marion Wendal, PhM3c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Virginia Bryant

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 April 1911

8. AGE: Years	Months	Days	If less than one day
34	6	11	hrs. min.

9. Birthplace: Missouri
(Town, county, and atate)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Arthur Bryant
13. Birthplace: Missouri (deceased)

MOTHER
14. Maiden name: Lola Bass
15. Birthplace: Missouri (deceased)

16. Informant: Wife: Mrs. Virginia Bryant
Address: 4553 Windsor Lane, Bethesda, Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10-13-45 (month) (day) (year)

Cemetery or crematory:

Location: Springfield, Missouri

18. Funeral director: Geo. [illegible] Wise J.C.F.

Address: 2900 M Street, N. W., Wash., D.C.

19. 10-13-45 19 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 October 19 45, at 0620a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med. Exam case 19, to 19, and that I last saw h alive on 19

Immediate cause of death	DURATION
Tuinal Poisoning	4½ hrs.
Due to: 24 tabs (3g. Ea.)	
Due to:	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Antopsy results:

PHYSICIAN: Please nnderline the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 10-12-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brocchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed 10-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10207

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Ashton MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Ashton MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: James T. Cashell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clair E. Cashell
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): August 21.1875

8. AGE: Years	Months	Days	If less than one day
70	2	10	hrs. min.

9. Birthplace: Montgomery County MD.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farm

FATHER
12. Name: Gustavus F. Cashell
13. Birthplace: Montgomery County MD.

MOTHER
14. Maiden name: Sarah Shaw
15. Birthplace: Montgomery County MD.

16. Informant: Mrs. Clair E. Cashell
Address: Ashton MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2. 1945 (month) (day) (year)
Cemetery or crematory: Union Rockville MD.
Location: Montgomery County MD.
18. Funeral director: Roy W. Barber
Address: Laytonsville MD.

19. 11-1-1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31 1945, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to Oct 31 1945
and that I last saw h alive on 10/30/45 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to	
Due to	
Other conditions Hypertension Heart Disease	—

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Marion Beard M.D.
M. D. or other
Address: Silver Spring, Md. Date signed 10/31/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

Reg. Dist. No. 17 — 1121 — 14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 8618 Old Bladensburg Road

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 8618 Old Bladensburg Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Ellen Chism

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Edward Chism

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9, 1857

8. AGE: Years: 88 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Jesse Edwards
13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Mary Ellen ~~Brooks~~ Chick
15. Birthplace: Washington D.C.

16. Informant: Camilla F. Beall
Address: 8618 Old Bladensburg Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 3 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Va

18. Funeral director: Frank Teich Sons Co

Address: 3605-14 St N.W.

19. Oct 1 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1945, at noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-25 1940, to 9-21-1945 and that I last saw h-er alive on 9-21-1945.

Immediate cause of death	Myocardial failure	DURATION: 10 days
Due to	arteriosclerosis, general.	30 yrs.
Due to	senility + coaheria	—
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Shaeffer M. D. or other

Address: 8005 Woodbury Drive Silver Spring, Md. Date signed: 10/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

10209 Reg. Dist. No. 725

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 805 - Maple Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cora Brown Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Charles Buckner Clark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1866

8. AGE: Years	Months	Days	If less than one day
79	7		hrs. ..... min.

9. Birthplace: LaPorte, Ind. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Clay Brown
13. Birthplace: Indiana

MOTHER
14. Maiden name: Bina Logan
15. Birthplace: Indiana

16. Informant: Mrs. O. P. M. Brown
Address: 2009 Belmont Rd., N.W., Wash. D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1945 (month) (day) (year)
Cemetery or crematory
Location: Washington, D. C.
18. Funeral director: S. T. Stevens Co.
Address: 2901 - 14th St. N.W.
19. Oct 12 1945 (Date rec'd by registrar) J. Nelson Lloyd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-12 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to 10-12 1945 and that I last saw h... alive on Oct 8 1945

	DURATION
Immediate cause of death: Cardiac Vascular renal disease	10 yrs.
Due to: Age.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: none made
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jno. W. Hyde M. D. or other
Address: 1801 - Eye N.W. Date signed: 10-12-45

1869

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-0)

16210

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: County Montgomery Co., 103 E. Underwood St.,
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 E. Underwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harriet M. H. Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife Dr. Eugene B. Clark
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb 16, 1857

8. AGE: Years	Months	Days	If less than one day
88			... hrs. ... min.

9. Birthplace Massachusetts
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name William Hamilton
13. Birthplace Mass.
MOTHER 14. Maiden name Sarah E. Stebbins
15. Birthplace Boston, Mass.
16. Informant George B. Clark
Address 103 E. Underwood St., Chevy Case, Md. Son
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1945 (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington, D.C.
18. Funeral director The S H Hines Co
Address 2901 14th St. N.W., Wash, D.C.
19. 10/10 1945 (Date rec'd by registrar) Wm E Jolies Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Octbr 10th 1945 at 3:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1944 to Oct 10th 1945
and that I last saw her alive on Octbr 6th 1945

	DURATION
Immediate cause of death Cardiac Hypertrophy	Several years
Due to	
Due to	
Other conditions General Oedema	6 mos

(Include pregnancy within 3 months of death)
Major findings of operations None made
Date of op.
Autopsy results None made
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address 2430-20th N.W. Washington 9, D.C. Date signed Oct 10th 1945

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

Reg. Dist. No. 1023 V4

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hosp-8600 Old Georgetown Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8426 Piney Branch Ct.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME

Mary C. CLARK

3.(b) Social Security Number

none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed.

6.(b) Name of husband or wife: Douglas B.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 27th 1866.

8. AGE: Years	Months	Days	If less than one day
79	8	23	..... hrs. ..... min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Retired.

11. Industry or business: — —

FATHER
12. Name: Daniel Weaver.
13. Birthplace: Penna.

MOTHER
14. Maiden name: Albertine Nome.
15. Birthplace: Penna

16. Informant: Mrs. Ruth M Clark.

Address: 8426 Piney Branch Cts - Silver Spring

17. Removal - Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 19th 1945 (month) (day) (year)

Cemetery or crematory:

Location: Dayton - Ohio

18. Funeral director: Barnes & Pumphrey.

Address: 8434 Ga Ave Silver Spring

19. Oct 20 1945 (Date rec'd by registrar) Josephine M. Shaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1945, at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-18 1945 to 10-20 1945 and that I last saw h. S R alive on 10-20 1945

Immediate cause of death	DURATION
CORONARY OCCLUSION	
Due to SENILE GENERALIZED ARTERIO SCLEROSIS	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. P. Andersen M.D.
M. D. or other

Address: 4201 Fessenden St N.W. Wash. D.C. Date signed: 10-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10212

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 45 POPLAR AVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES E. CRAMER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: MARY
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): JULY 30, 1863 1863

8. AGE: Years: 82 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: IND.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: ELI CRAMER
13. Birthplace: OHIO

MOTHER
14. Maiden name: LOUISE VANTUYL
15. Birthplace: N.Y.

16. Informant: MISS ALMA CRAMER
Address

17. REMOVAL Date thereof 10-29-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Lincoln Rd. N.E. Wash., D.C.

18. Funeral director: The J. H. Kries Co.
Address: 2901-14 St. N.W. Wash. D.C.

19. Oct 29 1945 Gladson Stodd Registrar
(Date rec'd by registrar)

T229

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29, 1945, at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October, 1941, to Oct. 29, 1945
and that I last saw h.i.m. alive on Oct. 29, 1945

	DURATION
Immediate cause of death: Cardiac dilatation	1 day
Due to: Arteriosclerosis	2 to 10 yrs.
Due to:	
Other conditions: Old age - debility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wm. A. Thomson M.D.
M. D. or other
Address: 1.3 Carroll St. N.W. Wash. D.C. Date signed 10-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

10213

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? four years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6024 Western ave,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ADDIE E. CREASON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Mike Creason
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1866

8. AGE: Years: 79 | Months: 1 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Josiah Watson
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Tebitha Beach
15. Birthplace: Kentucky

16. Informant: Lloyd W. Creason
Address: 6024 Western ave, Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 28 1945 (month) (day) (year)

Cemetery or crematory:
Location: Mayfield Kentucky

18. Funeral director: E.H. Hines Co
Address: 2901—14th St. N.W.

19. 10/25 1945 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1945, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3 1945, to Oct. 25 1945
and that I last saw h[illegible] alive on Oct. 23 1945

	DURATION
Immediate cause of death: Transitional carcinoma rt. eye	13 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: U.V. Wilcox II M.D. (M. D. or other)
Address: Garfield Memy. Hosp. Washington D.C. Date signed 10/25/45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-O)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

1. PLACE OF DEATH:
County Montgomery
City or town Rockville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Rockville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lilly M. Hilltrude Mary Teresa Cullen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 25-1859

8. AGE: Years 86 | Months 7 | Days 4 | If less than one day hrs. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual occupation Teacher Retired
11. Industry or business
FATHER 12. Name James Cullen.
13. Birthplace Ireland.
MOTHER 14. Maiden name Anna Madden.
15. Birthplace Ireland.
16. Informant Mother M. Constantine
Address Rockville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31-1945 (month) (day) (year)
Cemetery or crematory Mt Olivet Cemetery
Location Washington D.C.
18. Funeral director Albert S. Pike
Address 641-H St N.E. Wash. D.C.
19. 10/29 1945 Wm E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Oct 29 1945
and that I last saw h alive on Oct 28 1945

Immediate cause of death	DURATION
Chr myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Bouvier M. D. or other
Address 301-B N E Washington D.C. Date signed 10/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


OCT 31 1945
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

10215

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 22 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 653 Morris Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DAMM, Martin (n), CPO USN Retired Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Virginia Damm

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1869

8. AGE: Years	Months	Days	If less than one day
76	6	7	..... hrs. ..... min.

9. Birthplace: Hamburg, Germany (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER

12. Name: Martin Damm (deceased)

13. Birthplace: Germany

MOTHER

14. Maiden name: Johanna Eversen (deceased)

15. Birthplace: Denmark

18. Informant: wife: Mrs. Virginia Damm

Address: 653 Morris Pl., Wash., D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 10-24-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Ives Funeral Home

Address: 2847 Wilson Blvd., Arlington, Va.

19. 10-23- 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 October 1945, at 3:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 May 1945, to 22 Oct 1945 and that I last saw h... in alive on 22 Oct. 1945

	DURATION
Immediate cause of death: Carcinoma of rectum with metastasis	18 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry L. Blake M. D. or other

Address: USNH., Bethesda, Md. Date signed: 10-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

10216

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Cabin John (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs.

Hospital, Institution, or street address where death occurred: 6th St. Cabin John, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Cabin John (If outside city or town limits, write RURAL and give nearest town)

Street No. 6th Street (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Phemia Lou Davis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George H.

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): May 29, 1865

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: Washington Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Charles Henry Shaw

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Virginia Taylor

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. James Shaw, Brother

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/1/45 (month) (day) (year)

Cemetery or crematory: Potomac Cemetery

Location: Potomac, Md.

18. Funeral director: Wm Reuben Humphrey

Address: 7567 Wis. Ave. Bethesda, Md.

19. 11/1/45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 - 1945 at 8.10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1944 to Oct 30 1945 and that I last saw her alive on Aug 27 - 1945

Immediate cause of death	DURATION
Chronic myocardial insufficiency.	4 years
Due to Arterio-Sclerosis	6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: \ Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wheeler D Keefe M.D. or other

Address: Bethesda, Md. Date signed 10-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10217

Reg. Dist. No. 716

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4302 Sherford Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marie Eileen Doran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct. 24-44. 41

8. AGE:

Years	Months	Days	If less than one day
3	11	21	...hrs. ...min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
12. FATHER — Name: Harry Doran
13. FATHER — Birthplace: Minn.
14. MOTHER — Maiden name: Agnes Sullivan
15. MOTHER — Birthplace: Penna.
16. Informant: Harry Doran (Father)
Address: 4302 Sherford Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/5/45 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: Phila. Pa.
18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Md.
19. 10/5 1945 (Date rec'd by registrar) Wm E Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1945 at 5 15 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 44 to Oct 3 1945 and that I last saw her alive on October 3 1945

Immediate cause of death	DURATION
Cachexia due to dysphagia (bulbar origin)	11 wks
Due to Recurrence of glioma of floor 4th ventricle	13 wks
Due to Glioma of 4th ventricle	8 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Glioma, attached in floor of 4th ventricle Date of op. 3/28/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James F. O'Donnell M. D. or other
Address: 4307 Ewr Highway Bethesda Md. Date signed: 10/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10218

CERTIFICATE OF DEATH

(50)

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8310 - 16 St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fay A. Eichner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Clarence L.
6.(c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) Feb. 17 - 1899

8. AGE: Years 46 | Months — | Days — | If less than one day — hrs. — min.

9. Birthplace Texas (Town, county, and state)
10. Usual occupation H. W.
11. Industry or business

FATHER
12. Name J. Lee Aston
13. Birthplace Texas

MOTHER
14. Maiden name Amlye Ford
15. Birthplace Texas

16. Informant Mrs. Amlye Ford
Address Texas

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 26 - 45 (month) (day) (year)
Cemetery or crematory 2901 - 14th St
Location Wash. D.C.
18. Funeral director The S. H. Hines Co.
Address 2901 - 14 N W

19. Oct 26 (Date rec'd by registrar) 19 45 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 19 45 at 9:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 45 to Oct 26 19 45
and that I last saw h.e.r alive on Oct 26 19 45

Immediate cause of death	DURATION
Cancer of Rt Breast	2 Yrs
Due to with Skeletal Metastases	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations 9/43 Cancer Rt Breast
Date of op. Sept 1943
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lucie P. Campbell M. D. or other
Address Kensington Md Date signed 10/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13A-E)

10219

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)
Street No. 8716 Cameron (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hershel V Fitzcharles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lucille
6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1906

8. AGE: Years	Months	Days	If less than one day
39	7	24	..... hrs. ..... min.

9. Birthplace Hicksville, Ohio (Town, county, and state)
10. Usual occupation Engineer
11. Industry or business Johns Hopkins Univ. Silver Spr.
FATHER 12. Name Adrian A. Fitzcharles
13. Birthplace Ohio
MOTHER 14. Maiden name Elizabeth Windsey
15. Birthplace West Virginia
16. Informant Wife - Mrs. Lucille Fitzcharles
Address 8716 Cameron, Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8 1945. (month) (day) (year)
Cemetery or crematory Forest Lawn Cemetery
Location Bladensburg Rd. Prince Georges Co. Md.
18. Funeral director Arthur J. Talbert
Address 254 Carroll St., Takoma Park, D.C.
19. 10/6 1945 (Date rec'd by Registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 at 12:31 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Sept 1945 to 6 Oct 1945 and that I last saw him alive on 5 October 1945

Immediate cause of death	DURATION
Uremia	1 mo.
Due to acute glomerulonephritis.	? 1 mo.
Due to chronic glomerulonephritis	? years.
Other conditions Hypertrophy of the heart & Edema of Lungs.	? years 1 days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE S. Nowakowsky M.D. M. D. or other
Address Suburban Hosp. Date signed Oct 6, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

10220

2411 N. Charles St., Baltimore 30-37

CERTIFICATE OF DEATH

★ Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Millie Frazier

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	separated

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4 1921

8. AGE: Years: 24 | Months: 0 | Days: | If less than one day: hrs. min.

9. Birthplace: Gaithersburg
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Nathan Frazier
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Handy
15. Birthplace: Maryland

16. Informant: Rosalie McRoy
Address: Bethesda- 500 Grasmere Lane Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 (month) 19 (day) 45 (year)
Cemetery or crematory: St. Marys Cemetery
Location: Rockville, Md

18. Funeral director: Robert L. Snyder
Address: 246 N. Washington St. Rockville Md.

19. 10-19-45 (Date rec'd by registrar) Josephine A. Trotter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 19 45 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 45 to October 16 19 45 and that I last saw h.. alive on October 15 19 45

	DURATION
Immediate cause of death: Hemorrhagic encephalopathy	12 Hours
Due to: Injection of Morphine	
Due to: Disease of Secondary Syphilis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Hemorrhagic encephalopathy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Millie Webb 2d. M. D. or other
Address: Rockville, Md Date signed: 10/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

10221

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W.Va. County:

City or town: Wheeling
(If outside city or town limits, write RURAL and give nearest town)

Street No. 987 National Road #5
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

FRITZ, Robert William, Lt.(jg) USNR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Barbara Davis Fritz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-18-21

8. AGE: Years	Months	Days	If less than one day
24	1	4	hrs. min.

9. Birthplace: Wheeling, W.Va.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: Wm. P. Fritz
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Mrs. Majesky
15. Birthplace: W.Va.

16. Informant: Wife: Mrs. Barbara D. Fritz
Address: 987 National Road, Wheeling, W.Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 10-23-45 (month) (day) (year)

Cemetery or crematory: Greenwood Cemetery

Location: Wheeling, W.Va.

18. Funeral director: Geo. W. Wise, J.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 10-23- 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Oct. 19 45 at 5:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 19 45 to 22 Oct. 19 45 and that I last saw h... in alive on 22 Oct. 19 45

	DURATION
Immediate cause of death: Medulloblastoma, cerebellum	appr. 4 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: medulloblastoma of cerebellar vermis Date of op. 16 Oct. 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. H. Pudenz, R. H. Pudenz, Lt. (MC) USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 10-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10222

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Weeks

Hospital, Institution, or street address where death occurred: Mo. Melton's rest home, 9508 Biltmore Rd.

How long in hospital or institution? 6 Weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2304 No. Capital

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: Anna R Georgino

3.(b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Wid.

6.(b) Name of husband or wife: Christopher D.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 9. 1864

8. AGE: Years	Months	Days	If less than one day
80	10	21	..... hrs. ..... min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: David Lucy
13. Birthplace: Va.

MOTHER
14. Maiden name: Margaret Taylor
15. Birthplace: Va.

16. Informant: John C. Snyder

Address: 2304 No. Cap. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2, 1945 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Wash. D.C.

18. Funeral director: A. H. Hines Co.

Address: 2901-14th St. Wash. D.C.

19. Oct 30 1945 (Date rec'd by registrar) Joseph M Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1945, at 6:A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1945, to Oct. 30 1945

and that I last saw h.. alive on Oct. 29 1945

Immediate cause of death	DURATION
Cardiac dilatation	24 hrs.
Due to: general debility - old age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D
M. D. or other

Address: 113 Carroll St. N.W. Wash. D.C. Date signed Oct. 30, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

10223

★ Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural - Colesville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Mo
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural - Colesville.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 3 - Rockville.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Harry C. Geyer

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widow

6.(b) Name of husband or wife: Elsie Geyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27th - 1872.

8. AGE: Years	Months	Days	If less than one day
73	4	16.	hrs. min.

9. Birthplace: Penn.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Eli Geyer.
13. Birthplace: Pa

MOTHER
14. Maiden name: Mary Ellen Conrad.
15. Birthplace: Pa.

16. Informant: Mrs John H Hay - daughter
Address: Rockville Rt 3. Md

17. Rural (Burial, cremation, or removal. Which?) Date thereof Oct 15 - 1945 (month) (day) (year)
Cemetery or crematory: Flohrs, near Easttown
Location: Adams Co - Penna.
18. Funeral director: Warner & Pumphrey.
Address: 9434 - Georgia Ave Silver Spring Md
19. Oct. 13 19 45 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/13/ 19 45, at 8:45 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/11 19 45, to 10/13/ 19 45 and that I last saw h alive on 10/ 12/ 19 45

Immediate cause of death	DURATION
Terminal Hemorrhage	18 hrs
Due to: General Edema	2.
Edema	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Md Date signed: 10/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-a)

CERTIFICATE OF DEATH

10224

Reg. Dist. No. 2W3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. and 7 days.

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 2 mo. 7 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3100 Conn. Ave. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

David Cramer Glazer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Hebrew	Single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 13, 1929

8. AGE: Years	Months	Days	If less than one day
16	4	17	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER 12. Name: Morris H. Glazen

13. Birthplace: Leavenworth Kansas

MOTHER 14. Maiden name: Dorothy Cramer

15. Birthplace: Kansas City, Missouri

16. Informant: Records at W.S.H and Father.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1945 (month) (day) (year)

Cemetery or crematory: Washington Mem Pk

Location

18. Funeral director: B Damsky & Son

Address: 501 14th St NW

19. Oct 31 1945 (Date rec'd by registrar) J Wilson Dodd Registrar

1224

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30 1945, at 11 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1945, to 10/30/1945 and that I last saw him alive on 10/30/1945

Immediate cause of death	DURATION
Cachexia Jaundice	7
Cirrhosis of the liver	a few days
Due to:	
Due to:	
Other conditions: Hypochromia of anemia, Ruptured	Congenital

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: Declined

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas M. Hobolson, MD M. D. or other

Address: 500 Rhode Island Ave NW Date signed 10/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1025 225

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6419 Elliott Place

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Elmer Shirley Gallimore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Effie Nina Gallimore

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): June 29, 901

8. AGE: Years	Months	Days	If less than one day
44	3	6	..... hrs. ..... min.

9. Birthplace: Lexington, Davidson Co., N.C. (Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business: Mr. T. M. Woodall Inc.

FATHER — 12. Name: Mr. Marcellus Gallimore

FATHER — 13. Birthplace: Davidson Co., N.C.

MOTHER — 14. Maiden name: Adella Mae Shirley

MOTHER — 15. Birthplace: Davidson Co., N.C.

18. Informant: Sanitarium Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1945 (month) (day) (year)

Cemetery or crematory: Center Hill Church Cemetery.

Location: Lexington, N. C.

18. Funeral director: J. Arthur Stalker.

Address: 734 Carroll Ave. Takoma Park, Md.

19. Oct. 5 1945 (Date rec'd by registrar) J. Wilson Kidd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1945, at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1945, to Oct. 4 1945

and that I last saw him alive on October 4 1945

Immediate cause of death	DURATION
Cerebral Edema,	5 days
Slight hemorrage.	
Due to Congenital Annuerysm	44 yrs
Circle of Willis, Rt.	
Due to	
Other conditions Broncho-pneumonia	2½ days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wallace H. Mook M.D. M. D. or other

Address: 804 Carroll Ave. Takoma Park 12, Md. Date signed 10-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44

CERTIFICATE OF DEATH

10226

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Texas County:

City or town: Houston
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2514 Truxill St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HARRIS, David Allen, Slc V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

B.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 May 1926

8. AGE: Years	Months	Days	If less than one day
19	5	7	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Ben Harton Harris
13. Birthplace: Ill.

MOTHER
14. Maiden name: Margaret Szidon
15. Birthplace: Ill

16. Informant: Mo: Mrs. Margaret Harris
Address: 2514 Truxill St., Houston, Texas

17. removal (Burial, cremation, or removal. Which?) Date thereof: 11-1-45 (month) (day) (year)

Cemetery or crematory:

Location: Houston, Texas

18. Funeral director: Geo. W. Wise, 2900 M St. N.W.
Address: Washington, D. C.

19. 11-1- 45 (Date rec'd by registrar)

Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 October 19 45, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Oct 19 45, to 31 Oct. 19 45, and that I last saw h... in ...alive on 31 Oct. 19 45

Immediate cause of death	DURATION
Hemorrhage-Mediastinal Tumor	
Due to (histology undetermined at present)	
Due to Hodgkin's Disease of mediastinum. Duration: Unknown. Gen. G.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: mediastinal tumor

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. S. Bray, Comdr. (MC) USNR
M. D. or other

Address: US NH Bethesda, Md. Date signed: 11-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 10227 2W3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hrs.

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Fairfax

City or town: Falls Church

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Grove St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Hedgecock, Unnamed Baby Boy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 12, 1945

8. AGE: Years | Months | Days | If less than one day: 15 hrs. 55 min.

9. Birthplace: Takoma Park Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: William Clinton Hedgecock

13. Birthplace: Winston Salem, N.C.

MOTHER

14. Maiden name: Margaret Virginia Reed

15. Birthplace: Bailey's Crossroads, Virginia

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 15, 1945 (month) (day) (year)

Cemetery or crematory: George Peck Memorial Cem.

Location: Riggs Rd. Hyattsville Md.

18. Funeral director: Wilson Undertaking Co.

Address: 734 Eleventh St. NW Washington D.C.

19. Oct 17 1945 (Date rec'd by registrar) Nelson Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 Oct 45 19____ at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Oct 19 45 to 13 Oct 19 45 and that I last saw him alive on 13 Oct 19 45

Immediate cause of death	DURATION
ANOXIA	16 HRS
Due to: PULMONARY ATALECTASIS	16 HRS
Due to: PREMATURITY	16 HRS
Other conditions: NONE	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Marcus A. Damm M.D. M. D. or other

Address: 45 Carroll Ave. Takoma Park Md. Date signed: 13 Oct 45

Second name of wife changed by letter from informant filmed 5/18/46 G104. hg

10228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 513

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 903 Lewis Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 903 Lewis Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Arthur Hegeman

3.(b) Social Security Number: 578-07-2425

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married.
6.(b) Name of husband or wife: Mary Elizabeth Lou
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): Nov. 20, 1897
8. AGE: Years: 69 Months: 11 Days: 25 If less than one day: hrs. min.
9. Birthplace: Burlington, Conn. (Town, county, and state)
10. Usual occupation: Dept. manager
11. Industry or business
FATHER 12. Name: Unknown Hegeman
13. Birthplace: Long Island, N.Y.
MOTHER 14. Maiden name: Unknown Northstand
15. Birthplace: Long Island N.Y.
16. Informant: Mrs. Mary Elizabeth Lou Hegeman
Address: 903 Lewis Ave. Rockville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/29/45 (month) (day) (year)
Cemetery or crematory: Arlington Nath. Cem.
Location: Arlington, Va.
18. Funeral director: W. Reuben Pumphrey
Address: Rockville, Md.
19. Oct 26th 1945 (Date rec'd by registrar) Josephine D. Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1945 at 12 05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1945 to Oct. 26 1945; and that I last saw him alive on Oct. 25 1945.

Immediate cause of death	DURATION
Carcinoma of the left lung	6 mo.
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable carcinoma of left lung. Date of op. Sept. 1945
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Leatherwood M.D.
M. D. or other
Address: Rockville, Md. Date signed: 10/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (140)

10229

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 yrs
Hospital, institution, or street address where death occurred: 12 Woodland Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Monty.
City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Woodland Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ernestine C. Heyler
3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept 5 1868

8. AGE: Years 77 Months 1 Days 3 If less than one day ... hrs. ... min.

9. Birthplace Hamilton, Ohio (Town, county, and state)
10. Usual occupation retired gov't clerk
11. Industry or business

FATHER
12. Name Christopher Heyler
13. Birthplace Germany

MOTHER
14. Maiden name Philippine Bender
15. Birthplace Germany

16. Informant Mary Heyler
Address 12 Woodland Ave. Takoma Pk. Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct. 11 1945 (month) (day) (year)
Cemetery or crematory Lee's Crematorium
Location Wash. D.C.

18. Funeral director J. Wm. Lee's Sons Co
Address 300 4 St. N.E. Wash D.C.

19. Oct 9 1945 (Date rec'd by registrar) J. Nelson Dodd Registrar
1229

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945, at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19... to ... 19...
and that I last saw h... alive on case 19...

	DURATION
Immediate cause of death: Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other
Address Gaithersburg Md Date signed 10-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

10230

Reg. Dist. No. 21 E

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County: Montgomery

City or town: Gaithersburg (outside)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 A Rockwell Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME

Charles Simmons Houck, Jr.

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thelma G. Wnykoop

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): July 5, 1898

8. AGE: Years	Months	Days	If less than one day
47	3	19	....hrs. ....min.

9. Birthplace: Frederick county Maryland (Town, county, and state)

10. Usual occupation: Insurance Salesman

11. Industry or business

FATHER

12. Name: Charles Simmons Houck

13. Birthplace: Frederick Co. Md.

MOTHER

14. Maiden name: Virgie Cromwell

15. Birthplace: Frederick County, Md.

16. Informant: Clarence Carty

Address: Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 27 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick, Md.

18. Funeral director: Harry E. Carty Company

Address: Frederick, Md.

19. Oct. 25 1945 (Date rec'd by registrar) Abraham L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1945 at 2:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19.... to 19....

and that I last saw h... alive on 19....

Immediate cause of death	DURATION
Fracture of skull with intra-cranial hemorrhage	died instantly
Due to: struck by automobile	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 10-25-45

Where did injury occur? near Gaithersburg (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: Struck by auto Injured at work? no

23. SIGNATURE: Frank J. Bronstad M.D. Dep. Med. Exam M. D. or other

Address: Gaithersburg Md Date signed: 10-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10231

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Mont. Co

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Kenwood Club

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: 2113 S. St. N.W.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington, D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Thomas L. Hume

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Laura Cox

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1873

8. AGE: Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Investment Banking

11. Industry or business:

FATHER — 12. Name: Thomas L. Hume

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annie Pickrell

15. Birthplace: Washington, D.C.

16. Informant: Charles W. Hume, Some

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10/7/45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 10/7 1945 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3rd Med. Exam 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death:	
Coronary occlusion	died suddenly
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred J. Borchardt M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 10-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 16232 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md. 8600 Old Georgetown Rd.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Suburban Hosp., Bethesda Md.,

Stay in hospital or inst. (yrs., or mos., or days) 34 hrs.,

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Darnestown Pike, Rockville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Judge Henry J. Hunt III

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W.

6 (b) Name of husband or wife Rosamond W. A.

Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1887

8. AGE:

Years	Months	Days	If less than one day
57	2	1	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Judge - Retired

11. Industry or business

FATHER 12. Name Henry Hunt 2nd

13. Birthplace ? California

MOTHER 14. Maiden name Margaret Daum

15. Birthplace Washington D.C.

16. Informant Suburban Hosp. — A. Thie

Address 8600 Old Georgetown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/2/45 (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Md.

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 11/2 19 45 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30-45 19 at 8 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 to 19

and that I last saw him alive on October 30 1945.

	DURATION
Immediate cause of death	
Bronchopneumonia	10 days
Due to	
Due to Paralysis lower extremities	
Other conditions after poliomyelitis at 25-33 yrs	
Terminal cardiac failure	3 days.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Bronchopneumonia: Adhesive pericarditis

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Faulkner M.D.
M. D. or other

Address Rockville, Md. Date signed 10/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-1)

10233

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase 15
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4518 Stanford St.,
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME William James Hutchinson

3.(b) Social Security Number 577-05-2900

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife Estelle N. Hutchinson

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) JAN 21, 1881

8. AGE: Years	Months	Days	If less than one day
64 64	8	22	hrs. min.

9. Birthplace Augusta, KENTUCKY
(Town, county, and state)

10. Usual occupation JUSTICE OF PEACE

11. Industry or business

FATHER 12. Name William James Hutchinson

13. Birthplace WASHINGTON, D.C.

MOTHER 14. Maiden name AMELIA, SHANKLIN

15. Birthplace HUNTINGTON, W. VA.

16. Informant WIFE

Address 4518 Stanford St., Chev. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17, 1945 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Prince George County, Md.

18. Funeral director Wm. Lauren Lanphier

Address Bethesda, Maryland

19. 10/16 1945 Wm E Jabes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1945 at 11:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945 to Oct. 13 1945

and that I last saw h... alive on Oct 13 1945

Immediate cause of death	DURATION
acute congestive Heart Disease	1 wk.
Due to Chr. Cardio-Vascular degeneration	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Bauerfeind M.D.
M. D. or other

Address Bethesda, Md Date signed 10/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

*1 10234

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (Maryland.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Suburban Hospital

Stay in hospital or inst. (yrs., or mos., or days) Dead on arrival

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 5603 Sonoma Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dr. Hendrik Herman Juyntoll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Berta Juyntoll

6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 24- 1867

8. AGE:

Years	Months	Days	If less than one day
78	3	1	____ hrs. ____ min.

9. Birthplace Delft, Netherlands.
(Town, county, and state)

10. Usual occupation Retired Director of Natl Museum

11. Industry or business

FATHER
12. Name Abraham Juyntoll
13. Birthplace Netherlands

MOTHER
14. Maiden name Wilhelmina Schadee
15. Birthplace Netherlands

16. Informant Mrs. T.W. Scheltema

Address 5603 Sonoma Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/27/45 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Marygood

18. Funeral director Wm Reuben Pumphrey

Address Bethesda Md

19. 10/25 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25, 1945, at 3 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def. Med. Exam. 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Coronary occlusion — DURATION: died suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

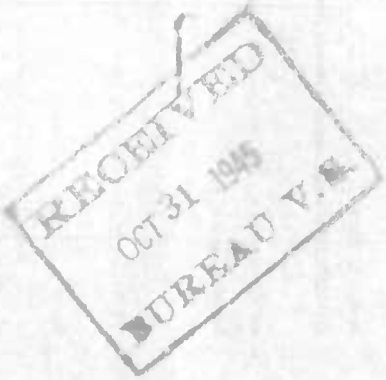
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J Broschart M.D. Def. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 10-25-45


RECEIVED
OCT 31 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

10235

Reg. Dist. No. 2 / 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg Co

City or town: Gaithersburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20Days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Gaithersburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Girtrude Keeney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Lewis Keeney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4th 1874

8. AGE: Years	Months	Days	If less than one day
1874 71	3	21	..... hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: "

FATHER — 12. Name: James E Sollers

13. Birthplace: Md

MOTHER — 14. Maiden name: Emily J Reisinger

15. Birthplace: Md

16. Informant: Methodist Home, H M Wilson

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/25/45 (month) (day) (year)

Cemetery or crematory: Louden Park Cemetery

Location: Baltimore Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Oct. 24 1945 (Date rec'd by registrar) Abraham L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23rd 1945 at 4 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3rd 1945 to 1945

and that I last saw h alive on Oct 23rd 1945

Immediate cause of death	DURATION
Coronary occlusion	about suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchat M. D. (M. D. or other)

Address: Gaithersburg Md Date signed 10-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

10236

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: (rural) Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 27 days

Hospital, Institution, or street address where death occurred:

U.S. Naval Hospital Bethesda Md.

How long in hospital or institution? 1 mo 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist. of Columbia County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3210 Northampton N.W. Washington

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna Khantzian

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Herman Khantzian

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 12/15/1902

8. AGE:

Years	Months	Days	If less than one day
42	10	12	...hrs. ...min.

8. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Tailoress

11. Industry or business

FATHER — 12. Name: Herman Cooper

13. Birthplace: Russia

MOTHER — 14. Maiden name: Clara Cooper

15. Birthplace: Russia

16. Informant: Mr. Eugene Robin, Son

Address: 4731 Georgia Ave., N.W. Wash D C

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 10 (month) 29 (day) 1945 (year)

Cemetery or crematory: Arlington National

Location: Arlington Virginia

18. Funeral director: Bernard Danzansky & Son

Address: 3501 14th St. N.W. Wash D C

19. (Date rec'd by registrar) 10/27/45 — M C Smith, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 October 1945, at 0150 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Aug 1945, to 27 Oct 1945

and that I last saw h.e alive on 26 Oct 1945

Immediate cause of death	DURATION
Glioma (astrocytoma) frontal lobe, right	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Tumor noted above — Date of op. 14 Aug, 1945

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Robert B Rudow Lt Cdr (MC) USNR, M. D. or other

Address: U.S. Naval Hosp. Bethesda — Date signed: 31 Oct 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

16237

★ Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year.
Hospital, institution, or street address where death occurred:
205 Flower Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Montgomery County: Md.
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 Flower Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Miranda Elizabeth Kimble

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Widowed

6.(b) Name of husband or wife: James D. Kimble
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Feb. 1. 1851.

8. AGE: Years	Months	Days	If less than one day
94	8	22	——— hrs. ——— min.

9. Birthplace: Hornby New York - Steuben County
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: David Lane
13. Birthplace: New York State
MOTHER 14. Maiden name: Miranda C Weed
15. Birthplace: New York State
16. Informant: Son - Wm D. Kimble
Address: 205 Flower Ave. Takoma Pk.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26, 1945 (month) (day) (year)
Cemetery or crematory: Maryland Cemetery
Location: Maryland N.J. New York
18. Funeral director: Arthur Parker
Address: 254 Carroll St. N.W. Takoma Park, D.C.
19. Oct 24 1945 (Date rec'd by registrar) J. Nelson Lodd Registrar
K-29

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1945, at 1:05 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1944 to October 23 1945
and that I last saw her alive on October 23 1945

Immediate cause of death	DURATION
Coronary Occlusion	Terminal
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op.
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A Stare M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 10/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10238

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: MONTGOMERY
City or town: BETHESDA
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 513 PARK L A.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: GABRIEL B. LIKENS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: DRUE G.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): FEB. 17, 1867 2/17/1867

8. AGE: Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace: KY. (Town, county, and state)
10. Osual occopation: RETIRED
11. Industry or business
FATHER 12. Name: JOHN H. LIKENS
FATHER 13. Birthplace: KY.
MOTHER 14. Maiden name: MARIA YORK
MOTHER 15. Birthplace: KY
16. Informant: E. O. LIKENS
Address: 513 PARK L A. BETHESDA. MD
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)
Cemetery or crematory
Location: HARTFORD, KY
18. Funeral director: S. H. HINES CO.
Address: 2901-14 ST. N.W. WASH, D.C.
19. 10/20 1945 Wm E Jackard Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1945, at 6:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-19 1945, to 10-20 1945 and that I last saw h.. alive on 10-19-45 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul D Lantuzano M.D. M. D. or other
Address: 3425 Wisconsin Ave Date signed: 10-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, Institution, or street address where death occurred:
9007 Mohawk Lane
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9007 Mohawk La.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Frank N. Loria

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): July 23, 1892

8. AGE: Years: 53 | Months: 2 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Plumbing & Heating Contractor

11. Industry or business:

FATHER
12. Name: Antonio Loria
13. Birthplace: Italy

MOTHER
14. Maiden name: Anna Caniglonia
15. Birthplace: Italy.

16. Informant: Mrs. Mary Loria
Address: 9007 Mohawk La. Bethesda Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/45 (month) (day) (year)
Cemetery or crematory: Arlington Natl. Cem.
Location: Virginia

18. Funeral director: Rev. Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Md.

19. 10/8 (Date rec'd by registrar) 1945 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7/45 19..., at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/7 19.43., to 10/6 1945
and that I last saw h.. alive on 10/4 19..45.

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ernest T. Benjamin M.D.
M. D. or other
Address: Bethesda, Md. Date signed 10/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

10240

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Willie St Clair Maguder

3.(b) Social Security Number 217-01-7261

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife —

7. Birth date of deceased (mo., day, yr.) Dec 28 1876

6.(c) If alive, give age — years

8. AGE:

Years	Months	Days	If less than one day
68	9	25	hrs. min.

9. Birthplace Maryland (town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name William Maguder
13. Birthplace Montgomery County Md
MOTHER 14. Maiden name Mary M Magruder
15. Birthplace Montgomery County Md
16. Informant Miss Ella P Plummer
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25 1945 (month) (day) (year)
Cemetery or crematory Oakham Md
Location Montgomery Co.
18. Funeral director Roy W Barber
Address Laytonsville Md
19. Oct 25 1945 (Date rec'd by registrar) Alveda G Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1945, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1944, to Oct 23 1945
and that I last saw him alive on Oct 23 1945

Immediate cause of death	DURATION
Cerebellum	
Due to Hemorrhage of Brain	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other
Address Gaithersburg Md Date signed Oct 24/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (15th)

CERTIFICATE OF DEATH

10241 223

★ Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hrs

Hospital, Institution, or street address where death occurred: Wash. San. + Hosp. Takoma Park, Md

How long in hospital or institution? 19 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington D.C. County: D.C.

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5357-29th N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME David Ernest ~~Unnamed Baby Boy~~ Marr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cauc	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1945

8. AGE: Years	Months	Days	If less than one day
			18 hrs. 41 min.

9. Birthplace: Takoma Park, Md. Montgomery Co. (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER

12. Name: Mr. Norman Clarence Marr

13. Birthplace: Chicago, Ill

MOTHER

14. Maiden name: Helen May McCenry

15. Birthplace: Pittsburg, Pa

16. Informant: Patients Chart (Mothers)

Address: Wash. San. + Hosp.

17. Clinical Laboratory (Burial, cremation, or removal. Which?) Date thereof 10/2/45 (month) (day) (year)

Cemetery or crematory: Washington Sanitarium + Hospital

Location: Takoma Park, Maryland

18. Funeral director: —

Address: —

19. Oct. 4 1945 (Date rec'd by registrar) J. Wilson Hodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-1 1945, at 7:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-30 1945, to 10-1 1945

and that I last saw him alive on 9-30 1945

	DURATION
Immediate cause of death: Meningomyelocele	1 day
Due to:	
Due to:	
Other conditions: Imperforate anus	1 day

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel M. Bryant M.D. M. D. or other

Address: Wash. D.C. Date signed 10-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10242

CERTIFICATE OF DEATH

Reg. Dist. No. 2-66

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5202 Roosevelt Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Marion L. McFarland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife William L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11, 1898

8. AGE: Years	Months	Days	If less than one day
47	6	28	..... hrs. ..... min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business
12. FATHER Name Wm J. Reisheas
13. Birthplace Washington D.C.
14. MOTHER Maiden name Ida Bowler
15. Birthplace Fredericksburg, Va
16. Informant Hospital Records
Address Bethesda, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/45 (month) (day) (year)
Cemetery or crematory Oak Hill Cem.
Location Wash. D.C.
18. Funeral director Wm Reuben Plumsdon
Address 7557 Wis. Ave. Bethesda Md
19. 10/10 1945 Wm E. Johns Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1945 at 1050A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945, to Oct 9 1945
and that I last saw h... alive on Oct 8 1945

Immediate cause of death	DURATION
Peritonitis from Intestinal Carcinoma	15 Months
Due to perforation of ascites caused by	
Due to Carcinoma of papilla of Vater	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 5011 Leighton Rd Date signed 10/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10243

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring — (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 hours.
Hospital, institution, or street address where death occurred: 308 Leighton Ave — Silver Spring, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C. (If outside city or town limits, write RURAL and give nearest town)
Street No. 307 East Clifton Terrace, N.W. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: McKiver, Miss ~~Margie~~ MAYME L.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 22. 1889

8. AGE: Years 56 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Cincinnatti Ohio (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Bureau of Printing & Engraving
FATHER — 12. Name: George M. Hines
FATHER — 13. Birthplace: Canada
MOTHER — 14. Maiden name: Nida Warnick
MOTHER — 15. Birthplace: Ohio
16. Informant: Mrs Nida Reid
Address: 308 Leighton Ave. Silver Sp. Md.
17. Disposition: Cedar Hill (Burial, cremation, or removal. Which?) Date thereof: Oct. 29. 1945 (month) (day) (year)
Cemetery or crematory: Cemetery Cedar Hill
Location: Prince George County, Md.
18. Funeral director: The S. H. Kies Co.
Address: 2401-14th St. N.W. Wash. D.C.
19. Oct 25 (Date rec'd by registrar) 1945 Josephine M. Schaaf, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-25-1945, at 2:32 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1936, to 10-25-1945; and that I last saw her alive on 10-25-1945

Immediate cause of death: (1) Gastro-intestinal hemorrhage; due to; (2) Ruptured esophageal varices Cirrhosis — DURATION: 36 hours
Due to: 10/28/'45; (3) Cirrhosis of liver Coronal years' duration;
Due to:
Complicated by: (4) Diabetes Crimes 1936, and
Other conditions: examinations. Cancer
(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: listed above, after death certificate had
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. B. Shoemaker M. D. or other
Address: 8005 Woodbury Drive, Silver Spring, Md. Date signed: 10-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10244

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Monty

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
Monty Co. Gen. Hosp.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Ellicott City R-2
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Musgrove

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Samantha Musgrove

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Apr. 12 1894

8. AGE:

Years	Months	Days	If less than one day
61	6	4	hrs. min.

9. Birthplace: Howard Co. Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farmer

FATHER
12. Name: John W. Musgrove
13. Birthplace: Howard Co. Md

MOTHER
14. Maiden name: Rachael L. Grimes
15. Birthplace: Howard Co. Md

16. Informant: Minnie L. Easton
Address: Ellicott City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-19-45 (month) (day) (year)

Cemetery or crematory: Mt Carmel

Location: Sunshine Md

18. Funeral director: J.C. Higinbotham

Address: Ellicott City Md

19. Oct 17 1945 (Date rec'd by registrar) Dr. Trudie B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1945, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam. 19 case to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Traumatic pneumonia	1 day
Intra-Thoracic hemorrhage	2 days
Due to: Crushed chest	2 days
Due to: struck by automobile	10-16-45
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 10-16-45

Where did injury occur? Glenelg (City or town) Howard (County) Md (State)

Injured at home, farm, industry, public place (where?): public place

Means of injury: automobile Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Md. Exam. M. D. or other

Address: Yanthenburg Md Date signed: 10-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

10245

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Suburban

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Carroll Springs Inn Seminary Rd. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Mrs Lucienne M Renso

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Marius E Renso

6(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 16 1886

8. AGE: Years	Months	Days	If less than one day
59	2	28	hrs. min.

9. Birthplace Montreal Canada (Town, county, and state)

10. Usual occupation H W

11. Industry or business

FATHER 12. Name Francis X Huot

13. Birthplace Quebec Canada

MOTHER 14. Maiden name Matilda Rheaum

15. Birthplace Montreal Canada

16. Informant Husband

Address Carroll Springs Inn Silver

17. REMOVAL TO BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct 15 1945 (month) (day) (year)

Cemetery ~~or crematory~~ ST RAYMOND

Location BRONX - NY

18. Funeral director Adams & Pumphrey

Address 8434 GA. AVE SILVER SPRING - MD.

19. OCT 16 1945 Wm E Lobe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1945, to Oct 14 1945, and that I last saw her alive on Oct. 14 1945.

	DURATION
Immediate cause of death: Acute Dilatation of Heart	5 min
Due to: Chronic Interstitial Nephritis (multiple hemorrhages)	20 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W B Wanless M.D. M. D. or other

Address 943 Bonifant St. Silver Spring Md Date signed Oct 14 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: B. Chevy Chase, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8/27/45 - 10/16/45

Hospital, institution, or street address where death occurred:

Bethesda Suburban Hospital

How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Seabrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Wm. William L. Phillips

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Dora E. Phillips

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Lewis P. Phillips

FATHER — 13. Birthplace: Hyattstown, Md.

MOTHER — 14. Maiden name: Alice Baker

MOTHER — 15. Birthplace: Frederick City, Md.

16. Informant: Mrs. Dora E. Phillips

Address: Seabrook, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/45 (month) (day) (year)

Cemetery or crematory: Lanham, Md. Cem.

Location: Lanham, Md.

18. Funeral director: Wm. Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 10/19 19 45 Wm E Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/16 19 45 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/27 19 45 to 10/16 19 45

and that I last saw him alive on 10/16 19

Immediate cause of death: Peritonitis	DURATION
Due to: ruptured urinary bladder.	
Due to:	
Other conditions: enlarged heart	
Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. S. T. Hamlin, Jr., M.D. M. D. or other

Address: Bethesda Suburban Hosp. Date signed 10/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-13 10257

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or street~~ address where death occurred:
104 Jefferson Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Jefferson Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Reverend Forrest J. Prettyman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband~~ wife Elizabeth Rebecca Stone-Street Prettyman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7, 1860

8. AGE: Years	Months	Days	If less than one day
85	6	5	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Minister
11. Industry or business
FATHER 12. Name Barrett Prettyman
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden name Lydia Forrest Johnston
MOTHER 15. Birthplace Maryland
18. Informant E. Barrett Prettyman
Address 106 Woodlawn Ave. Kenwood
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-14-45 (month) (day) (year)
Cemetery or crematory Rockville Union Cemetery
Location Rockville Maryland
18. Funeral director Warner E. Pumphrey
Address Silver Spring Md.
19. Oct. 14 19 45 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945 at 4:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1943 to Oct. 12 1945
and that I last saw him alive on October 12 1945

Immediate cause of death	DURATION
Carcinoma of prostate	5 years
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Father E. Kuhn M.D. M. D. or other
Address Rockville, Md. Date signed 10/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10196

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (10/10/45)

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3216 Minnesota Avenue, S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: RACHEL, Alec "A", M/lc USN Ret. Inactive

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Anna Rachel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-30-90

8. AGE: Years	Months	Days	If less than one day
55	2	3	hrs. min.

9. Birthplace: Wyoming (Town, county, and state)

10. Usual occupation: Engineering

11. Industry or business:

FATHER
12. Name: Jacob Rachel
13. Birthplace: Austria (deceased)

MOTHER
14. Maiden name: Mary Petras
15. Birthplace: Austria (deceased)

16. Informant: Wife: Mrs. Anna Rachel
Address: 3216 Minnesota Ave., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St., S. E., Wash., D.C.

19. Oct. 4 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 October 1945, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Sept. 1945, to 3 Oct. 1945 and that I last saw him alive on 3 Oct. 1945

Immediate cause of death	DURATION
Abscess of Brain, Multiple	
Due to: Tuberculosis	
Due to:	
Other conditions: Pulmonary TB, far adv.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Multiple TB abscesses of brain, Pulm. TB.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

SIGNATURE: Burnell F. Eckardt Jr. M.D. M. D. or other

Address: US Naval Hosp. Bethesda Date signed: 10/4/45

3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54) X

CERTIFICATE OF DEATH

10248

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? six hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? six hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Calif. County:

City or town: San Diego
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3821 Kettner Blvd., San Diego, Calif.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RICE, Loyd Benjamin, CWO USMC Ret.Active

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Josephine D. Rice

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 Jan. 1892

8. AGE: Years	Months	Days	If less than one day
53	9	4	hrs. min.

9. Birthplace: Michigan
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Marine Corps

FATHER
12. Name: Elmer Rice
13. Birthplace: (deceased)

MOTHER
14. Maiden name: Edora Rice
15. Birthplace: (deceased)

18. Informant: Wife: Mrs. Josephine D. Rice

Address: 3821 Kettner Blvd., San Diego, Calif.

17. removal (Burial, cremation, or removal. Which?) Date thereof 10-29-45 (month) (day) (year)

Cemetery ~~or crematory~~: Fort Rosecrans National

Location: San Diego, Calif.

18. Funeral director: Geo. W. Wise J.C.F.

Address: 2900 M St., N.W., Wash., D.C.

19. 10-28-45 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 October 19 45, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Oct. 19 45, to 28 Oct. 19 45 and that I last saw him alive on 28 Oct. 19 45

Immediate cause of death	DURATION
Glioma (glioblastoma multiforme) frontal lobe left	4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Robert H. Pudenz Injured at work?

SIGNATURE: Robert H. PUDENZ, Lt.Condr.(MC)USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 10-28-45

VS A15 2/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

10249

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montg.

City or town Seneca Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg

City or town Seneca Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jessie D. Sager

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Lorenzo D.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	6	..... hrs. ..... min.

9. Birthplace Seneca Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Kirby

13. Birthplace Southern Maryland

MOTHER 14. Maiden name Magie Good

15. Birthplace Southern, Maryland

16. Informant Mrs. Margarie LaTaye

Address Seneca, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/45 (month) (day) (year)

Cemetery or crematory Darnestown Cem Pine Grove Chapel

Location Darnestown Md.

18. Funeral director Wm Reuben Pumphrey

Address Bethesda, Md.

19. 10-18-45 (Date rec'd by registrar) Josephine D. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 19 45 at 4:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 45 to Oct 15 19 45

and that I last saw h.. alive on Oct 15 19 45

	DURATION
Immediate cause of death Apoplexy	1 day
Due to Hemorrhage of Brain	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Ring Shirley M.D. M.D. or other

Address Gaithersburg Md. Date signed Oct 15/45

10250

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Montgomery County, Maryland
City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 Langley Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sellman Miss May

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	9	..... hrs. ..... min.

9. Birthplace Comus Maryland (Town, county, and state)
10. Usual occupation housewife
11. Industry or business own home
12. FATHER Name Mr. John F. Sellman
13. Birthplace Frederick, Maryland ?
MOTHER 14. Maiden name Misk Poole
15. Birthplace Fredrick, Maryland ?
16. Informant Washington Sanitarium and Hospital records
Address Takoma Park, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof October 12 1945 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md
18. Funeral director William B. Hellen
Address Barnesville, Md.
19. Oct 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1945, at 6 05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2, 1945 to Oct 9 1945
and that I last saw h. alive on Oct 9 1945

Immediate cause of death	DURATION
Cardiac failure	3 days
Due to Carcinoma of right breast (Operated Oct 3, 1945)	2 yrs ?
Due to	
Other conditions Senility (78 yrs old) Chr. myocardial dis.	yrs ?

(Include pregnancy within 3 months of death)

Major findings of operation Carcinoma Rt. breast. Date of op. Oct 3, 1945
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Lod N. Calvert M.D.
Address 7894 Ga Ave S.S. Md. M.D. or other Date signed 10/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

10251

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

425 Greenbriar Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 425 Greenbriar Drive

(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR #1

3. (a) FULL NAME Rev. Raymond Clyde Sorrick

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife May Hoover Sorrick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1893

8. AGE:

Years	Months	Days	If less than one day
51	9	22	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Lutheran Clergyman

11. Industry or business

FATHER

12. Name Samuel Sorrick

13. Birthplace Penna.

MOTHER

14. Maiden name Flora Taylor

15. Birthplace Penna.

16. Informant Mrs. May Hoover Sorrick

Address 425 Greenbriar Drive, Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1945 (month) (day) (year)

Cemetery or crematory Fairview

Location Martinsburg, Blair Co., Pa.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19 Oct 17 (Date rec'd by registrar) 19 45 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1945 at 2.40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 21 1944 to Oct 16 1945

and that I last saw h. alive on Oct. 15 1945

Immediate cause of death	DURATION
General Carcinomatosis of abdomen	
Due to Primary Adenocarcinoma of rectum	15 Mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations (1) Polyp + tag removed (2) Rectal resection (3) Colostomy Date of op. 7/21/1944 (A) 4/24/45 (B)

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. H. Oliver M.D. M. D. or other

Address 401 Kennedy St NW Date signed Oct. 16, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

10252

Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs.

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring - Route #1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Unnamed Baby Boy Thompson

3.(b) Social Security Number: 579-05-4807

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 10-12-45

8. AGE: Years | Months | Days | If less than one day: 7 hrs. ____ min.

9. Birthplace: Takoma Park, Montgomery, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Jess Nelson Thompson

FATHER — 13. Birthplace: Germantown, Md.

MOTHER — 14. Maiden name: Anna Belle Dodson

MOTHER — 15. Birthplace: Poolesville, Md.

18. Informant: Sanitarium Records

Address: Takoma Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15, 1945 (month) (day) (year)

Cemetery or crematory: George Mack Memorial Cem.

Location: Riggs Rd. Hyattsville, Md.

18. Funeral director: Arthur Stokes

Address: 257 Carroll Ave. Takoma Park, D.C.

19. Oct. 15 1945 (Date rec'd by registrar) J. Nelson Lloyd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-13 1945, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-12 1945, to 10-13 1945, and that I last saw him alive on 10-12 1945

Immediate cause of death	DURATION
Prematurity - 5 mo. gestation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Emma Hughes M. D. or other

Address: Takoma Park, Md Date signed 10-13-45

10253

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 4½ yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rockville Pike
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Irene Margaretta Viett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Charles Henry Viett
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 13, 1881

8. AGE: Years: 64 Months: 3 Days: 5 If less than one day: hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: (unknown) Schrieber
13. Birthplace: Germany

MOTHER
14. Maiden name: Tena Viett
15. Birthplace: Germany

16. Informant: C. H. Viett
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/21/45 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Rockville, Md.

18. Funeral director: Wm. Rauken Dempsey
Address: Rockville, Maryland.

19. 10-18-45 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: 10/18/45 19..., at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Ruptured left ventricle	8 hours
Due to: Myocardial infarction	2 weeks
Due to: Coronary sclerosis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Wm. Rauken Dempsey M. D. or other
Address: Rockville, Md. Date signed: 10/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21L

1. PLACE OF DEATH:
County: Montgomery
City or town: Near Damascus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
R. F. D. Monrovia
How long in hospital or institution? At home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Near Damascus
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. Monrovia,
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3.(a) FULL NAME: ALICE ROBERTA WARFIELD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel Warfield deceased
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 20, 1872

8. AGE: Years	Months	Days	If less than one day
73	7	2	-- hrs. --- min.

9. Birthplace: Montgomery County, Maryland.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: William H. Baker
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Jemima K. Purdum
15. Birthplace: Maryland.

16. Informant: H. Deets Warfield
Address: Monrovia, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 24 1945 (month) (day) (year)
Cemetery or crematory: Montgomery Chapel
Location: Claggettsville, Near Damascus, Md.

18. Funeral director: Roy W. Barber
Address: Laytonsville, Maryland

19. Oct 23 1945 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1935 to October 22, 1945 and that I last saw her alive on October 17, 1945

Immediate cause of death: Carcinoma of liver — DURATION: 1 year ?
(Secondary) Metastatic
Due to: from unknown source,
possibly head of pancreas.
Due to:
Other conditions: Associated icterus and secondary anemia.
(Include pregnancy within 3 months of death)

Major findings of operations: No operations.
Date of op.:
Autopsy results: No post-mortem.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. McKendree Boyer, M.D.
Address: Damascus, Maryland Date signed: 10-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

10255

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months, 28 days

Hospital, institution, or street address where death occurred:
USNH Bethesda, Md.

How long in hospital or institution? 3 Months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wisconsin County:

City or town: Milwaukee
(If outside city or town limits, write RURAL and give nearest town)

Street No. 748 North 34th St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Edward George Weisfeldt, Lt.(jg) (S) USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUGUST 12 1920

8. AGE: Years	Months	Days	If less than one day
25	2	0	hrs. min.

9. Birthplace: Milwaukee, Wisconsin
(Town, county, and state)

10. Usual occupation: Officer

11. Industry or business: U. S. Navy

FATHER 12. Name: Max Weisfeldt

13. Birthplace: Russia

MOTHER 14. Maiden name: Dora Holzman

15. Birthplace: Russia

16. Informant: Harry I. Weisfeldt (brother)

Address: 801 E. Sylvan Ave. Milwaukee Wis.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-13-45 (month) (day) (year)

Cemetery or crematory: SPRINGHILL

Location: MILWAUKEE WISCONSIN

18. Funeral director: George W. Wise Co. JCF

Address: 2900 M. St. N.W. Wash. D

19. 10-13-45 19.... (Date rec'd by registrar) M.L. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 12 1945, at 2110 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 - 14 1945, to 10 - 12 1945 and that I last saw h.i.m.w. alive on 10 - 12 - 1945

Immediate cause of death	DURATION
TOXEMIA	3 MOS.
Due to COLITIS ULCERATIVE	2 YRS.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: COLITIS ULCERATIVE. Date of op. 7-17-45

Autopsy results: NO AUTOPSY PERFORMED

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eilif C. Hanssen CDR(MC)USNR
M. D. or other

Address: U.S. Naval Hosp. Bethesda, Md. Date signed 10-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-J4)

CERTIFICATE OF DEATH

10256

Reg. Diat. No. 22

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
9 Dennwood Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Dennwood ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Minna Weiss

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 25 1897

8. AGE: Years	Months	Days	If less than one day
47	9	23	hrs. min.

9. Birthplace: Newark N.J.
(Town, county and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Nathaniel Adams
13. Birthplace: N.J.

MOTHER
14. Maiden name: Gertrude Gluck
15. Birthplace: N.J.

16. Informant: Lewis Weiss
Address: 9 Dennwood ave. Takoma Pk.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1945. (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Emma Ave & Ga. Extended
18. Funeral director: J. Arthur Stellerz
Address: 254 Carroll St. Takoma Park, D.C.
19. Oct 15 19 45 J. Nelson Gold Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 19 45 at 11:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 Med. Exam. 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Asphyxia due to
Illuminating gas poisoning
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION
Instant
Instant
Some

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 10-18-45
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D.
Sept Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 10-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change is shown on addition of birthdate

10257

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 22-3

1. PLACE OF DEATH:
County: Montgomery.
City or town: Takoma Park md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days.
Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital - Takoma Pk. md.
How long in hospital or institution? 22 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1708 Webster st. n.w.
(If rural, give LOCATION)
2.(a) If veteran, name war: no.

3. (a) FULL NAME: Lawrence W. White

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Alice S. White
7. Birth date of deceased (mo., day, yr.): Jan. 18, 1879 8.(c) If alive, give age: 66 years
Birth date of deceased: February 14, 1872

8. AGE:

Years	Months	Days	If less than one day
73	8	2	..... hrs. ..... min.

9. Birthplace: De Kalb Co. Alabama (Town, county, and state)
10. Usual occupation: Physician
11. Industry or business: Retired

FATHER
12. Name: Charles White
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Mary Sargeant
15. Birthplace: South Carolina

16. Informant: Records Washington Sanitarium Hospital and Mrs. Alice White. - 1708 Webster St. N.W. Washington, D.C.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 16 1945 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Deal Funeral Home
Address: 4812 - Lafayette Wash. D.C.
19. Oct 16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1945 at 5:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 1945 to Oct. 16 1945 and that I last saw him alive on October 15 1945

Immediate cause of death	DURATION
Multiple Myeloma	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: 0
Date of op. 0
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: 0 Injured at work?

23. SIGNATURE: Chas. H. Nolan M.D.
M.D. or other
Address: 500 Edmond St. NW Date signed

R2a

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

10258

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 211

Village or City Damascus and No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Ronald W. White If U.S. Veteran specify WAR

(a) Residence: No. St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, end year) Feb 25 1943.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (yeers) spent in this occupation

12. BIRTHPLACE (city or town) Damascus
(State or country) Maryland.

FATHER

13. NAME Benjamin L. White

14. BIRTHPLACE (city or town) Birmingham
(State or country) Alabama

MOTHER

15. MAIDEN NAME Bessie M. Rinehart

16. BIRTHPLACE (city or town) Damascus
(State or country) Maryland

17. INFORMANT Benjamin L. White
(Address) Wheaton md.

18. BURIAL, CREMATION, OR REMOVAL
Place Damascus, md. Date Oct 5 1945

19. UNDERTAKER J. B. Beall, Inc.
(Address) Damascus md.

20. FILED Oct. 5 1945 Della V. Burdette
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 3 (Dey) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1945, to October 3, 1945.

t last saw him alive on October 3, 1945; death is said to have occurred on the date stated ebove, et 2:00 P.m.

The **PRINCIPAL CAUSE OF DEATH** end related causes of Importance were es follows:

	Date of onset
Sarcoma, left orbit	1½ years

Other **Contributory Causes** of Importance:

Neme of operation Date of

Whet test confirmed diagnosis? Wes there en autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) James P. Kerr M. D.

(Address) Damascus, Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Perilonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN